BLUEBONNET TRAILS COMMUNITY SERVICES (BTCS)
CONSENT TO MH SERVICES/RIGHTS ACKNOWLEDGMENT

Name:_____ Case #: _____

Individual in services/Representative should initial for consent/verification to the left. Write NA or Refused for each section not initialed.

_____ Individual in services' / Representative's Initials	CONSENT TO SERVICES I hereby request and consent to services for myself/dependent which may include, but is not limited to routine/crisis screening, diagnostic assessments, laboratory screens, residential services, and other treatment/services (e.g. counseling, vocational training, field trips, transportation for provided services, etc.) recommended and considered necessary by Bluebonnet Trails Community Services staff. I understand that upon completion of assessments, a more detailed plan of services will be offered to me. I understand that I have the option to accept or reject any recommendations for services. I have been informed that any information regarding my Bluebonnet Trails services is subject to release only by my informed and written consent or by subpoena and/or court order. I have also been informed that identifying information about me may be exchanged between components of the Texas Health and Human Services (HHSC) delivery system and other designated/contracted providers for continuity of care purposes. I understand that this consent can be revoked by the undersigned at any time, except to the extent that action has been taken in reliance on it. In order to revoke consent, I will contact my Case Manager/Rehabilitation Service Provider for assistance.
_____ Individual in services'/ Representative's Initials	RIGHTS ACKNOWLEDGMENT I have received a copy of and a complete explanation of my rights as an individual in services of the MHA. I have been informed that my family/guardian/advocate would receive a copy of the rights that have been explained to me. I understand that if I have questions about my rights, I may ask MHA staff for clarification, and all of my rights will be reviewed with me annually. ____ I have received a copy of the "Handbook of Consumer Rights" ____ I have received a copy of the "Rights of the Elderly" (clients 55+) ____ I have received a copy of the "General Public Complaint and Positive Feedback Procedure" ____ I have received a copy of the "Appeals Procedure"
_____ Individual in services'/ Representative's Initials	AUTOMATED APPOINTMENT REMINDERS I understand that I may receive reminders through automated phone calls, texts or emails. I understand that it is my responsibility to secure the different mediums (voicemail, cell phone, or email account) by which I may receive an automated reminder. ____ If you do not wish to receive reminders initial here.
_____ Individual in services' / Representative's Initials	COMMUNICATION FOR OPPORTUNITIES TO PARTICIPATE IN IMPROVEMENT OF HEALTHCARE OPERATIONS I understand that I may be notified by Bluebonnet Trails Community Services of opportunities to participate in programs designed to improve the quality of care. I understand that participation in these programs are voluntary and will not affect the receipt of services in BTCS. I understand that I may receive notifications of these programs through, but not limited to, the following mediums (phone, mail, email, in person). ____ I agree to be notified of opportunities to participate in improvement of healthcare operations

_____ Individual in services'/ Representative's Initials	RECEIPT OF NOTICE OF PRIVACY PRACTICES ____ I have received a copy of the "HIPAA Notice of Privacy Practices"
_____ Individual in services' / Representative's Initials	PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION TO REGIONAL HEALTH INFORMATION EXCHANGE BTCS securely shares data with the regional Health Information Exchange (HIE) for the purposes of coordination of care, quality improvement of individuals' care, and for statistical analysis. ____ I have reviewed the Patient Authorization specific to the regional HIE that I am receiving services in and authorize the release of information to those HIE or HIEs. ____ I have reviewed the Patient Authorization specific to Community Health Centers of South Central Texas (CHCSCT) and authorized the exchange of information with them for the purposes of coordinating my treatment and care. ____ I have reviewed the Patient Authorization specific to the collaboration between Texas A&M College of Nursing, BIS Clinic – Bedias, MHMRA of Brazos Valley and Bluebonnet Trails Community Services and authorize the exchange of information with them for the purposes of coordinating my treatment and care.
_____ Individual in services' / Representative's Initials	FOR MEDICAID RECEPIENTS ONLY Patient Authorization to review and receive information for the Medicaid Eligibility Health Information System (MEHIS) for the multiple purposes of: 1. Enables verification of Medicaid patient eligibility. 2. Allows provider staff to check-in patients at time of appointment 3. Reduces duplication of services and aides in better coordination of care 4. Provides the ability for providers and their delegates to view a patient's: a. Health Summary page b. Vaccination information c. Prescription drug information d. Health events, including I understand these statements.

_____ Individual in services' / Representative's Initials	PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION TO PARTNERING SCHOOL DISTRICTS I understand the local independent school district (ISD) may occasionally use identifying information gathered from services provided by BTCS for the purpose of program evaluation about school attendance, scholastic achievement, cost containment, and similar measures. School District Authorized to receive patient information (please cirlcle): Bastrop ISD Burnet Consolidated ISD Elgin ISD Georgetown ISD Giddings ISD Hutto ISD Jarrell ISD La Grange ISD Leander ISD Lockhart ISD Marble Falls ISD Prairie Lea ISD
	Round Rock ISD Schulenburg ISD Seguin ISD Taylor ISD I do not consent to information sharing with a local ISD.
_____ Individual in services'/ Representative's Initials	DISABILITY FORMS Psychiatric evaluations are conducted for the purpose of delivering clinical care and/or for determining the necessary level of care, and are not designed to evaluate for the presence or absence of a disability. Therefore, BTCS psychiatrists may provide treatment records, but will not complete forms that request a determination of a disability, or that relate to a request for a benefit based on presence or level of disability. I understand this statement.
_____ Individual in services'/ Representative's Initials	OPPORTUNITY TO REGISTER TO VOTE ____ I was given the opportunity to register to vote upon admission to services.

_____ _____ _____
Signature of Individual in Services/Legal Representative Initials Date

_____
Relationship

_____ _____
Signature of Staff/Presenter & Title Date

_____ _____
Witness Date